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Joint United Nations Programme on HIV/AIDS

Note by the Secretary-General

The Secretary-General has the honour to transmit to the Economic and Social Council the report of the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), prepared pursuant to Council resolution 2013/11.

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Report of the Executive Director of the Joint United Nations Programme on HIV/AIDS

Summary

The present report was prepared in response to Economic and Social Council resolution 2013/11, in which the Council requested the Secretary-General to transmit, at the substantive session of 2015, a report prepared by the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) on progress made in implementing a coordinated response by the United Nations system to the HIV/AIDS epidemic.

The global community has been presented with an historic opportunity. Dramatic scientific advances, combined with more than three decades of experience in scaling up HIV programmes, have cleared a way forward to end AIDS as a public health threat once and for all. In 2013 and 2014, UNAIDS focused its efforts on accelerating progress towards the 2015 targets set out in the 2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, in support of the achievement of Millennium Development Goals 3 to 6 and 8, and on galvanizing global action towards ending the AIDS epidemic by 2030. Its efforts built on major gains in the HIV/AIDS response, including substantial declines in new HIV infections and AIDS-related deaths.

Uniting and synergizing the efforts of 11 co-sponsors and the secretariat, the Joint Programme has helped to lead and coordinate the global AIDS effort. Advocacy by UNAIDS has kept AIDS high on the global political agenda and inspired a growing roster of low- and middle-income countries to increase domestic funding for the response. Normative guidance by the Joint Programme has assisted countries in implementing evidence-based programmes and in leveraging rapidly evolving scientific knowledge. UNAIDS has remained the central provider of strategic information on the epidemic and the response at the global, regional and country levels. It has also served as a consistent and vocal advocate for an inclusive response grounded in human rights and gender equality and for equitable service access for key populations and vulnerable groups. UNAIDS-supported innovation at the country level has helped to overcome service barriers and roll out new scientific advances, and the Joint Programme is a global leader in galvanizing and supporting the mobilization of communities affected by the epidemic. By leveraging the comparative advantages of diverse United Nations bodies and partners, UNAIDS plays a unique role in strengthening multisectoral responses.

Encouraging progress notwithstanding, the AIDS epidemic is not over. A majority of people living with HIV are still not receiving antiretroviral therapy, in part because more than 50 per cent of people living with HIV do not know their serostatus. While declining globally, new HIV infections are rising in some countries, in particular where services are not prioritized for most-affected populations. Although there are increasing domestic resources for the response, donor assistance for AIDS declined in 2013.

Modelling led by the Joint Programme shows that accelerated action and front-loaded investments over the next five years can bring the AIDS epidemic to an end. In response, the Joint Programme is assisting countries in developing and

implementing ambitious fast-track targets for 2020, including a new HIV treatment target to maximize the proportion of people living with HIV who achieve viral suppression, and complementary prevention and non-discrimination targets beyond 2015. New resources will be needed to reach these targets, and smart investments will be required, in line with the principles of shared responsibility and global solidarity. A fast-track response will necessitate an inclusive, people-centred approach that effectively reaches those being left behind. As part of this population- and location-focused response, in 2014, the Joint Programme launched a new initiative to catalyse action by cities to mobilize municipal resources towards the goal of ending the epidemic.

To ensure its readiness to successfully navigate a rapidly evolving global landscape and to lay the foundation to end the epidemic by 2030, the Joint Programme is working to develop a new UNAIDS strategy for the period 2016-2021, with the aim of ensuring that it is "fit for purpose" for the post-2015 era. Consistent with the multidimensional nature of the AIDS challenge, steps to end AIDS as a public health threat need to be mainstreamed across the sustainable development goals. UNAIDS and the broader AIDS response also offer important lessons that can strengthen and sustain global health and development efforts more generally. In 2016, the General Assembly will convene a high-level meeting on HIV/AIDS, which will offer a potentially transformative opportunity to strengthen global resolve and redouble strategic efforts to bring the epidemic to an end.

I. Update on the global AIDS epidemic

1. Substantial advances continue to be recorded in the global AIDS response. The number of people newly infected with HIV in 2013 (2.1 million (1.9 million-2.4 million)) was 38 per cent lower than in 2001. In 2013, 1.5 million (1.4 million-1.7 million) people died of AIDS-related causes, down 35 per cent from the peak in 2005. In 2013, the number of children newly infected with HIV (240,000 (210,000-280,000)) represented a 58 per cent decline from 2002.

2. AIDS nevertheless remains the sixth cause of death globally, the leading cause of death in sub-Saharan Africa and the leading cause of death worldwide among women of reproductive age. As at December 2013, some 35 million (33.2 million-37.2 million) people were living with HIV. Sub-Saharan Africa remains most heavily affected, accounting for 71 per cent of people living with HIV and 68 per cent of new HIV infections in 2013. Women represent 52 per cent of all people living with HIV globally and 57 per cent in sub-Saharan Africa. In some countries, young women aged 15 to 19 are up to five times more likely to be living with HIV than their male counterparts. Several populations are disproportionately affected by the epidemic: globally, men who have sex with men are 19 times more likely to be living with HIV than the general population; HIV prevalence is almost 12 times higher among sex workers than among the population as a whole; and transgender women are 49 times more likely to acquire HIV than all adults of reproductive age. Globally, 13 per cent of all people who inject drugs are living with HIV.

3. Persistent gaps in the response contribute to the continuing severity of the epidemic. As at June 2014, more than 60 per cent of all people living with HIV were not receiving antiretroviral therapy, in large part because more than half of all people living with HIV do not know their HIV status. While 38 per cent of adults living with HIV obtained antiretroviral therapy in 2013, only 24 per cent of children living with HIV received treatment. In many countries, key populations and other vulnerable groups continue to be left behind in the response, while gender inequality, criminalization and other human rights violations remain significant barriers to progress.

II. Joint United Nations Programme on HIV/AIDS

4. As the only co-sponsored Joint Programme in the United Nations, UNAIDS[1] is a tangible example of a collaborative, multisectoral response to a complex and multifaceted issue. In its resolution E/RES/2013/11, the Economic and Social Council specifically recognized the value of the lessons learned from the unique approach of the Joint Programme for the post-2015 development agenda and that the Joint Programme offers the United Nations a useful example, to be considered as a

[1] The Joint Programme draws on the experience and expertise of 11 co-sponsors, namely, Office of the United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), World Food Programme (WFP), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Office on Drugs and Crime (UNODC), United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO), World Health Organization (WHO) and the World Bank, and a secretariat.

way to enhance strategic coherence, coordination, results-based focus and country-level impact, in accordance with General Assembly resolution 67/226 on the quadrennial comprehensive policy review of operational activities for development of the United Nations system. As reflected in its inclusive governing structure, the Joint Programme represents a commitment to robust multisectoral and integrated action, synergistic partnerships, evidence- and rights-based action, equality in access and outcomes and a focus on sustainability.

A. Getting to zero: the UNAIDS 2011-2015 strategy and the 2011 Political Declaration on HIV and AIDS

5. The work of the Joint Programme is inspired and guided by the vision, set forth in the UNAIDS 2011-2015 Strategy: Getting to Zero, of a world with zero new HIV infections, zero discrimination and zero AIDS-related deaths. Providing a framework for the Joint Programme's collective efforts, the strategy is aimed at revolutionizing HIV prevention, catalysing the next phase of treatment, care and support and advancing human rights and gender equality in the response. Under the strategy, UNAIDS established goals for 2011-2015 that are aligned with the key targets and commitments of the 2011 Political Declaration.

6. Supporting countries to develop and implement strategies towards "getting to zero", the Joint Programme advanced and led the compilation of the most extensive and focused data collection available on HIV epidemic and response trends and specific populations at high risk of HIV infection, including through three flagship reports in 2014: *The Gap Report*; *Fast-Track: Ending the AIDS Epidemic by 2030*; and *UNAIDS OUTLOOK: The Cities Report*. A total of 181 Member States submitted national reports in 2014 as part of the global AIDS response progress reporting. UNAIDS also requested reporting for key programmes on a biannual basis and for subnational entities, thereby promoting an even more focused programming approach. Increased availability of real-time data was achieved through the use of new technology.

7. Taking into account UNAIDS-commissioned modelling indicating that the next five years represent a critical window of opportunity to lay the groundwork towards ending the AIDS epidemic by 2030, the UNAIDS Programme Coordinating Board asked the Executive Director of UNAIDS to undertake a multi-stakeholder consultative process to update and extend the UNAIDS 2011-2015 strategy through 2016-2021. The Programme Coordinating Board reaffirmed the commitment to the UNAIDS vision of the three zeros and the strategic directions in the 2011-2015 strategy and requested that the updated strategy be aligned with the quadrennial comprehensive policy review of operational activities for development of the United Nations system (General Assembly resolution 67/226), taking account of the 2011 Political Declaration and ongoing discussions on the post-2015 sustainable development goals. The updated UNAIDS strategy for the period 2016-2021 and a new Unified Budget, Results and Accountability Framework for the six-year period will be submitted to the Programme Coordinating Board at its 37th meeting in October 2015.

8. In June 2014, the General Assembly decided to convene a high-level meeting on HIV/AIDS in 2016. The meeting provides an important opportunity to shape and accelerate the next phase of the AIDS response, driving results and accountability.

B. Delivering as one

9. The Joint Programme works to ensure that the United Nations system "delivers as one" in supporting national AIDS responses, in line with and responding to the General Assembly resolution on the quadrennial comprehensive policy review of operational activities for development of the United Nations system. UNAIDS has a clear division of labour among the 11 co-sponsors and the secretariat. With the aim of leveraging the core competencies, mandates and comparative advantages for technical support provision of each co-sponsor and the secretariat, the division of labour designates convening and partner agencies in 15 thematic areas.[2] The division of labour helps the Joint Programme to avoid duplication and harness collaboration and coordination and clarifies roles and responsibilities.

10. At the regional and country levels, the Joint Programme is operationalized through joint teams and joint support programmes, supported and coordinated through seven UNAIDS secretariat regional support teams.

11. At the country level, the UNAIDS Country Director works under the leadership of the Resident Coordinator to advance the United Nations country team's coordinated response to AIDS. In 74 countries, joint United Nations teams on AIDS are in place, enhancing coherence, accountability and the strategic impact of technical support. In many countries, joint teams have been expanded to include non-United Nations partners, broadening the coordination of technical support. In 52 countries, United Nations partners have implemented joint United Nations programmes of support on AIDS, integrating the entirety of the United Nations system's support for the national response into a single framework. In 2013, the Joint Programme supported 120 countries in undertaking midterm reviews of progress towards the 10 global targets and commitments of the 2011 Political Declaration, allowing a clearer understanding of persistent gaps and opportunities to accelerate gains.

12. Particular steps have been taken to intensify coordination and enhance the strategic impact of United Nations AIDS assistance in 38 high-impact countries[3] that, together, account for 85 per cent of new adult infections, 93 per cent of new infections among children and 90 per cent of AIDS-related deaths.

C. Accountability

13. The UNAIDS 2011-2015 strategy is operationalized by the Unified Budget, Results and Accountability Framework, which maximizes the coherence,

[2] The 15 thematic areas are prevention of sexual transmission; prevention of mother-to-child HIV transmission; HIV treatment; HIV/tuberculosis; prevention among people who inject drugs; prevention among men who have sex with men, sex workers and transgender people; punitive laws, stigma and discrimination; meeting the needs of women and girls; prevention among young people; HIV-related social protection; HIV in humanitarian emergencies; HIV, food and nutrition; workplace and the private sector; HIV and education; and national strategic planning.

[3] The 38 high-impact countries are Angola, Botswana, Brazil, Burundi, Cambodia, Cameroon, Central African Republic, Chad, China, Côte d'Ivoire, Democratic Republic of the Congo, Djibouti, Ethiopia, Ghana, Guatemala, Haiti, India, Indonesia, Iran (Islamic Republic of), Jamaica, Kenya, Lesotho, Malawi, Mozambique, Myanmar, Namibia, Nigeria, Russian Federation, Rwanda, South Africa, South Sudan, Swaziland, Thailand, Uganda, Ukraine, United Republic of Tanzania, Zambia and Zimbabwe.

coordination, impact and accountability of the United Nations response to AIDS. Outlining key actions, strategic directions and funding allocations cascading from the strategy's goals and from the 2011 Political Declaration targets and commitments, the Unified Budget, Results and Accountability Framework provides the whole results chain from inputs to impact and allows Member States and other stakeholders to hold the Joint Programme accountable. The co-sponsors receive resources through the Framework to contribute to their work on AIDS. This funding serves as a catalyst for leveraging greater resources from the budgets of the co-sponsor organizations and other funding streams.

14. The UNAIDS performance monitoring report submitted annually to the Programme Coordinating Board summarizes the achievements of the Joint Programme across the 10 targets at the country, regional and global levels towards the vision of the three zeros and outlines key challenges and lessons learned. The report provides an understanding of the contributions of the Joint Programme as a whole and of individual co-sponsors and the secretariat.

15. Performance reporting under the Unified Budget, Results and Accountability Framework has been facilitated through a web-based tool, the Joint Programme Monitoring System, introduced in 2012. The system, which received reports from 106 United Nations country teams and/or UNAIDS country offices in 2013, has increased the ability of the Joint Programme to make rapid adjustments in response to performance information. Annual peer reviews evaluate progress and performance, identify areas where additional efforts are needed and ensure that lessons learned are taken on board for future planning.

16. In 2014, at the request of the Programme Coordinating Board at its 32nd meeting, UNAIDS reported the results of a midterm review of progress under the 2011-2015 Unified Budget, Results and Accountability Framework, drawing on external assessments of UNAIDS from almost 150 stakeholders. The midterm review found that UNAIDS has made significant contributions to the global AIDS response through such key functions as leadership, advocacy, strategic information, targeted country-level technical support, strengthened accountability and a focus on high-impact countries and key populations. It also confirmed that the coherence and effectiveness of the Joint Programme have improved under the Unified Budget, Results and Accountability Framework.

17. The Unified Budget, Results and Accountability Framework for 2016-2021 will be aligned with the planning cycles of United Nations funds and programmes, as mandated by the quadrennial comprehensive policy review of operational activities for development of the United Nations system.

D. Partnership

18. Itself an innovative partnership within the United Nations system, the Joint Programme prioritizes partnership as a core value, convening transformative, inclusive partnerships to unite the United Nations, Governments, people living with HIV, civil society, major financing institutions, academia, science, the media, influential public figures and the private sector. The Joint Programme's approach to partnerships has achieved historic results, including a 99 per cent drop in the cost of lifesaving antiretroviral medicines over the past 10 years and a reduction in the time

required to introduce new medical innovations in resource-limited settings, from 15 years to 3 years.

19. In 2014, UNAIDS signed a new memorandum of understanding with one of its most important strategic partners, the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Joint Programme supports the Global Fund through participation in country coordinating mechanisms, the publication of normative guidance, the provision of strategic information, assistance to countries to translate national strategies or investment cases into compelling concept notes, and the provision of technical support through the full funding cycle, including by assisting countries in implementing and monitoring Global Fund grants.

20. UNAIDS also works closely with the United States President's Emergency Plan for AIDS Relief, the leading provider of international HIV assistance, to ensure the success of programmes funded by the Emergency Plan. The President's Emergency Plan for AIDS Relief participates in numerous inter-agency mechanisms coordinated by the Joint Programme.

21. The Joint Programme prioritizes partnerships with non-governmental organizations. It is the only United Nations entity with civil society represented on its governing body. It assists different civil society actors, including people living with HIV and key affected communities, in participating fully and meaningfully in decision-making, advocacy and accountability. In addition, it helps to define and promote civil society's strategic role in the delivery of HIV-related services.

22. The Joint Programme has entered into an array of innovative partnerships with civil society organizations and networks, such as PACT, a coalition of 26 organizations serving — and led by — young people that was established with the aim of reigniting the AIDS youth movement. UNAIDS also prioritizes partnership with the private sector, including within governance, as reflected by the participation of the chief executive officers of GlaxoSmithKline and Cipla in the 34th meeting of the Programme Coordinating Board.

III. Towards the 2015 deadline: results in 10 priority areas

23. In the 2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, Member States embraced a series of 10 outcome targets or commitments.

A. Reduce sexual transmission of HIV by 50 per cent

24. The reduction in sexual transmission of HIV is primarily responsible for the sharp declines in new HIV infections in recent years. Compared with surveys from 2001-2006, household surveys in sub-Saharan Africa in 2007-2013 indicate an increase in young people's HIV-related knowledge and greater condom use among adults. Voluntary medical male circumcision, which reduces the risk of female-to-male sexual HIV transmission by about 60 per cent, is being scaled up, with 6 million men in sub-Saharan Africa having been circumcised since 2007, including 1 million in 2013. The Joint Programme has closely collaborated with international partners to focus scarce resources on geographic and population "hotspots" where new HIV infections are most likely to occur.

25. Despite progress, there were still 2.1 million new HIV infections in 2013, with increases in infections in a number of regions and geographical locations within countries and among certain population groups. Stronger HIV prevention efforts are urgently needed among young people (ages 15 to 24), who in 2013 accounted for 31 per cent of all new HIV infections globally. Particular risks are faced by adolescent girls and young women, who on average acquire HIV five to seven years earlier than men in sub-Saharan Africa. Studies sponsored by the World Bank have found that various youth-focused cash transfer schemes reduce HIV incidence and sexual risk behaviour, with especially pronounced outcomes for young women. In 2014, the United Nations Children's Fund (UNICEF) and the UNAIDS secretariat, with the engagement of all co-sponsors, initiated the "All in" agenda, to address the serious gaps in the AIDS response for adolescents. This effort has two bold objectives by 2020: to reduce HIV infections among adolescents by at least 75 per cent and to increase the number of adolescents living with HIV on lifesaving treatment to 80 per cent. The United Nations Educational, Scientific and Cultural Organization (UNESCO) and the United Nations Population Fund (UNFPA) have supported the scale-up of sexuality education for young people in 115 countries, including joint efforts with the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) on peer education to address gender-based violence in schools. UNICEF spearheaded the collection and dissemination of strategic information focused on children and adolescents.

26. Although shipments of male condoms steadily increased, they have subsequently plateaued at a level substantially shy of the recommended levels. The availability of female condoms has significantly risen in recent years, although 40 male condoms are still shipped for every one female condom. To guide and incentivize manufacturers, the Joint Programme and key partners published generic specification and pre-qualification guidelines for female condoms. UNFPA is the world's leading purchaser of female condoms.

27. Despite their proven value, prevention services for key populations at higher risk continue to be lacking. Only about one third of countries report having programmes for sex workers, and the proportion of men who have sex with men reached by prevention programmes in 20 countries declined from 59 per cent in 2009 to 40 per cent in 2013. In an effort to strengthen evidence-based programmes for key populations, in 2014, the World Health Organization (WHO) issued the first *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* which, among other things, recommended the administration of pre-exposure antiretroviral prophylaxis for men and transgender women who have sex with men, as well as for serodiscordant couples.

28. The evidence base for the prevention of sexual HIV transmission continues to evolve. In early 2015, multiple multi-country studies were evaluating various "combination prevention" packages and an array of candidate microbicides for women. In 35 countries, joint United Nations teams on AIDS aided the translation of research on new prevention technologies into implementation and scale-up.

B. Reduce HIV transmission among people who inject drugs by 50 per cent

29. The world is not on track to halve the number of new HIV infections among people who inject drugs, with little change detected in the HIV burden in this population. Globally, an estimated 1.7 million of the 12.7 million people who inject drugs are living with HIV. HIV prevalence among people who inject drugs is rising in Asia and the Pacific and in a number of sub-Saharan African countries. Drug injection-related transmission is driving national epidemics in Eastern Europe and Central Asia. In 30 countries surveyed, HIV prevalence is higher among women who inject drugs than among male injectors (13 per cent versus 9 per cent).

30. WHO normative guidance has identified a comprehensive package of nine priority interventions to reduce HIV infection among people who inject drugs. To support implementation, the Joint Programme provides extensive technical support and advocacy. In addition, the United Nations Office on Drugs and Crime (UNODC) has collaborated with partners to identify 24 high-priority countries for intensified support in scaling up evidence-based responses for people who inject drugs.

31. Globally, however, coverage for needle and syringe programmes is still less than 20 per cent, and only 79 of 192 countries report offering opioid substitution therapy. Widespread criminalization of drug use, including the imposition of mandatory detention and even the death sentence for people convicted of drug violations in several countries, deters people who inject drugs from accessing essential services and discourages public health and human rights-grounded responses.

32. Responding to the need for strengthened action, the UNAIDS Programme Coordinating Board devoted a full day at its 35th meeting, in December 2014, to discuss the acceleration of progress towards the goal of halving HIV transmission within this population. Participants explored factors undermining effective responses for people who inject drugs and showcased examples of successful national efforts to overcome impediments. The special session of the General Assembly on the world drug problem, to be held in 2016, offers a critical opportunity to build consensus for drug policies that better address the needs of people who inject drugs.

C. Eliminate new HIV infections among children and substantially reduce AIDS-related maternal and child deaths

33. In 2013, 67 per cent of pregnant women living with HIV received antiretroviral medicines. Progress continued in the first six months of 2014, with the number of pregnant women receiving antiretroviral medicines increasing by 13 per cent. The annual number of children newly infected with HIV in 21 high-burden countries fell below 200,000 for the first time in 2013. Globally, since 2009, more than 900,000 new HIV infections among children have been averted owing to the provision of antiretroviral medicines to pregnant women living with HIV.

34. Such advances reflect national success in implementing the recommendations of the Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive: 2011-2015. An inter-agency task team, co-convened by UNICEF and WHO, aligns work with 28 partners to the Global

Plan. In 2013, WHO recommended the immediate initiation of antiretroviral therapy for all pregnant women and children living with HIV, regardless of CD4 cell count.

35. Children living with HIV continue to experience limited access to lifesaving HIV treatment. In 2013, only 42 per cent of HIV-exposed children received early infant diagnostic services within the first two months of life, and studies indicate that up to half of children who undergo early infant diagnostic testing do not receive their test results. For those diagnosed with HIV, the array of antiretroviral regimens available is much more limited than the options available for adults.

36. The urgent need to close the treatment gap for children with HIV has spawned numerous initiatives. In 2014, the President's Emergency Plan for AIDS Relief partnered with the Children's Investment Fund Foundation, launching a $200 million initiative to double the number of children receiving antiretroviral therapy over two years in African countries. Jointly launched by UNICEF, WHO and the Elizabeth Glaser Pediatric AIDS Foundation, the Double Dividend initiative seeks to better align paediatric HIV treatment with maternal, neonatal and child health. Other partners are also collaborating on initiatives to improve the scale-up of HIV diagnostic and treatment services for children. At its 35th meeting, in December 2014, the UNAIDS Programme Coordinating Board asked UNAIDS to work with relevant partners to establish a global platform for coordination of the various paediatric treatment initiatives to maximize coherence and impact.

D. Reach 15 million people living with HIV with antiretroviral therapy

37. As at June 2014, 13.6 million people were receiving antiretroviral therapy, putting the world on track to reach the global goal of providing HIV treatment to at least 15 million people by December 2015. Antiretroviral therapy has averted 7.6 million deaths globally since 1995, including 4.8 million deaths in sub-Saharan Africa, and has added 40.2 million life years since the beginning of the epidemic.

38. The Joint Programme provides extensive technical support to aid countries in scaling up high-quality HIV treatment services. The 2013 WHO *Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection* recommended earlier initiation of antiretroviral therapy; the use of optimally simple, potent and tolerable HIV treatment regimens; and the phase-out of suboptimal regimens. In 2013, research supported by the World Food Programme (WFP) advocated leveraging food and nutrition to improve HIV treatment outcomes, including adherence; WFP has implemented programmes in 31 countries. The UNAIDS secretariat has established an HIV treatment situation room, which uses modelling to estimate up-to-the-minute treatment scale-up and offers a granular analysis of treatment access to national partners and UNAIDS regional offices.

39. At its 33rd meeting, the UNAIDS Programme Coordinating Board asked the Joint Programme to support country- and region-led processes to develop a new HIV treatment target for the post-2015 era. Following multi-constituency consultations in all regions and at the global level, the Joint Programme launched a new HIV treatment target for the post-2015 era at the 2014 International AIDS Conference. The new "90-90-90" target provides that by 2020: (a) 90 per cent of all people living with HIV will know their HIV status; (b) 90 per cent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and (c) 90 per cent of all people receiving antiretroviral therapy will achieve viral suppression.

40. The 90-90-90 target has been embraced by international donors, national Governments, civil society and other partners. At a high-level side event at the General Assembly in September 2014, the Heads of State of Ghana, South Africa and Switzerland and the United Sates Secretary of State endorsed the target. The Joint Programme is now aiding countries in translating the 90-90-90 global target into national benchmarks and action plans.

41. Diagnostics, which are critical to effective medical management of HIV, remain underutilized. Most people living with HIV do not know their HIV status and most people with diagnosed HIV infection lack access to essential viral load testing technology. In 2014, the Joint Programme partnered with the MAC AIDS Fund in a global campaign to increase knowledge of HIV serostatus among young people, leveraging the influence of international performing artists.

42. To effectively leverage diagnostics to accelerate progress, the Joint Programme has joined with the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States Government and the African Society of Laboratory Medicine to establish the Diagnostics Access Initiative. As the first outcome, the Joint Programme collaborated with partners to negotiate a new global price ceiling for the world's leading viral load test, lowering the price for viral load tests by at least 40 per cent with projected savings of $150 million over the next five years.

E. Reduce tuberculosis deaths among people living with HIV by 50 per cent

43. Tuberculosis is still the leading cause of death among people living with HIV. From 2004 to December 2012, tuberculosis-related deaths among people living with HIV declined by 36 per cent, with 17 countries experiencing declines of at least 50 per cent. WHO estimates that collaborative HIV/tuberculosis activities prevented about 1.3 million deaths in 2005-2012. In 2013, 70 per cent of tuberculosis patients known to be HIV-positive were receiving antiretroviral therapy, an improvement over prior years but still short of the global goal of 100 per cent coverage by 2015.

44. The Joint Programme has supported countries through normative guidance and technical and capacity-building support. Technical support by WHO has supported the purchase of more than 4.2 million Xpert MTB/RIF cartridges in 95 countries. UNICEF aided countries in adapting global guidelines on HIV/tuberculosis co-infection among children.

F. Close the global AIDS resource gap

45. The Joint Programme has advanced advocacy for a shift from traditional cooperation relationships to shared responsibility and global solidarity approaches. From 2006 to 2011, some 80 countries increased their domestic investments for AIDS-related spending by more than 50 per cent. The African Union embraced a road map for a new response to AIDS, tuberculosis and malaria, and all the Presidents of the States members of the Central American Integration System endorsed the development of a sustainability strategy action and monitoring plans for sustainable HIV investments in the region. The Joint Programme continues to promote the strategic investment approach, supporting countries to focus on priority

areas, populations and interventions, ensure value for money and multiply benefits across broader health and development outcomes.

46. Total funding for the AIDS response continued to rise, reaching $19.1 billion in 2013. Low- and middle-income countries now cover a majority of the financing for the AIDS response. Among traditional international donors, however, funding declined by 3 per cent in 2013.

47. The Joint Programme works closely with such key funders as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the President's Emergency Plan for AIDS Relief. In 2012 and 2013, the Joint Programme successfully aided five early applicant countries under the Global Fund's new funding model, generating total HIV funding of $371 million.

48. By November 2014, 38 countries had either developed or were currently working on investment cases for response sustainability, with support from the Joint Programme. These processes have generated forward-looking national commitments, including the reallocation of resources towards high-impact interventions, enhanced resource targeting for key populations and geographic locations, commitments to increase domestic AIDS spending, and consideration of various innovative financing mechanisms, such as airline ticket tax levies.

49. At a multi-stakeholder dialogue on AIDS financing, hosted by the Joint Programme, participants highlighted that the ongoing need for shared responsibility includes both global resources and increased domestic support for the response, as well as stronger efforts — supported by the Joint Programme — to increase efficiencies and reduce costs across all resource streams. Participants welcomed the catalytic role of the Joint Programme in mobilizing political leadership, advocacy and resources, as well as the broadening of the UNAIDS donor base. In that regard, they noted in particular the addition of new donors from Africa, including the Congo, Côte d'Ivoire and Senegal, to the core budget. The dialogue also raised civil society resourcing shortfalls as an important concern, stressing that collective work is needed to help to identify gaps and ensure a continuing social movement for HIV.

G. Meet the specific needs of women and girls and eliminate gender inequalities and gender-based abuse and violence

50. Women and girls continue to be heavily affected by HIV, representing 52 per cent of all adults living with HIV globally and 57 per cent in sub-Saharan Africa. In 2013, 64 per cent of the 250,000 new HIV infections occurring in older adolescents (15 to 19 years) were among girls. In some settings, up to 45 per cent of adolescent girls report that their first sexual experience was coerced. Fear of violence and other indicators of gender inequality undermine the ability of women and young girls to protect themselves from HIV infection.

51. The share of countries with a policy, law or regulation in place to reduce violence, including sexual assault, rose from 38 per cent in 2010 to 77 per cent in 2012. The proportion of countries collecting data on the links between gender-based violence and HIV increased from 1 per cent in 2010 to 27 per cent in 2012. The leadership capacity of women and girls living with and affected by HIV was strengthened through the support of the United Nations Development Programme (UNDP), UN-Women and the secretariat in 68 countries in the period 2012-2013;

however, countries reporting the participation of women living with HIV in formal planning and review mechanisms for the national AIDS response declined from 66 per cent in 2010 to 61 per cent in 2012. In many cases, gender-sensitive policies have not translated into action, and improved sex- and age-disaggregated data are needed to ensure targeted programming and financing. Towards that aim, UN-Women and multiple partners led a process to agree on a set of standardized indicators for the programmatic areas of gender and HIV.

52. The work of the Joint Programme on gender equality is guided by the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV, which has been officially launched in 80 countries. Among those countries, 76 per cent reported having a multisectoral HIV strategy that includes a specific component for women, although only 38 per cent reported that they had a budget component focused on women. With the support of the Joint Programme, 27 countries have completed a gender assessment of their national HIV responses, and 20 countries are currently undertaking or preparing for a gender assessment. The addition, in 2012, of UN-Women as a co-sponsor of the Joint Programme has strengthened the capacity of UNAIDS to effectively address the epidemic's gender dimensions, including through the United Nations Trust Fund to End Violence against Women administered by UN-Women, which annually supports a number of government and civil society initiatives to address violence and HIV.

H. Eliminate stigma and discrimination and reduce punitive laws against people living with HIV or at highest risk of HIV

53. Surveys through the People Living with HIV Stigma Index document that a substantial proportion of people living with HIV experience stigma and discrimination in employment, housing and health-care settings, with a heavy burden on women and girls and members of key populations. More than 60 countries have statutes in place criminalizing HIV transmission, exposure or non-disclosure, and such prosecutions have also occurred in dozens of other countries under non-HIV-specific laws. Injecting drug use and at least some aspects of sex work are almost universally criminalized; 76 countries criminalize sex between members of the same sex, including seven countries where this is punishable by death; and transgender people struggle to obtain legal identification that aligns with their gender identity. Such punitive legal measures deter individuals from seeking health-care services and increase the likelihood that people will be placed in vulnerable situations that increase the risk of HIV acquisition.

54. Legal and policy framework trends are mixed. The proportion of countries reporting the existence of anti-discrimination laws protecting people living with HIV (61 per cent in 2012) has remained stable, while a number of countries have imposed new legal sanctions on same-sex sexual behaviour and/or gay rights advocacy. The proportion of countries reporting legal aid systems for people living with HIV reached 45 per cent in 2012.

55. In the period 2013-2014, the Joint Programme remained a leading global advocate for human rights-based approaches to AIDS. In 2012, UNAIDS supported action on HIV and legal environments in 84 countries, and the secretariat partnered with the Global Network of People Living with HIV to further roll out the Stigma Index to more than 50 countries. The Joint Programme supported legal assessments

in more than 50 countries, the review of draft legislation, civil society groups working on human rights issues, and intensive engagement by national stakeholders. As homophobic legislation emerged in various countries, the Joint Programme worked locally to support communities negatively affected by those initiatives and to ensure the continuity of vital services for groups affected by such laws. In 2013, ILO launched the VCT@WORK initiative, supported across the Joint Programme, to reach 5 million workers with voluntary and confidential HIV counselling and testing by 2015. In addition, the Joint Programme issued guidance on initiatives to reduce stigma and discrimination and increase access to justice in national responses, as well as a costing tool for human rights programmes. The Inter-Agency Task Team on HIV in Emergencies, which is led by the Office of the United Nations High Commissioner for Refugees (UNHCR) and WFP, engaged in extensive activities and advocated for greater focus on HIV and emergencies.

I. Eliminate HIV-related travel restrictions on entry, stay and residence

56. In June 2011, 49 countries, territories and areas imposed some form of restriction on the entry, stay and residence of people living with HIV based on their HIV status. Since then, 10 countries have removed their restrictions or officially clarified that they do not apply such HIV-related travel restrictions. In 2013, UNAIDS worked with GBCHealth to generate a pledge opposing HIV-related restrictions, which has been signed by more than 40 chief executive officers worldwide. The Joint Programme continued to support countries in reviewing and removing travel restrictions, including the Republic of Korea, the Republic of Moldova and Mongolia. The UNAIDS-launched global advocacy campaign against discrimination, featuring Nobel Prize laureate Aung San Suu Kyi, focused worldwide attention on outdated, discriminatory and ineffective travel restrictions.

J. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response

57. The Joint Programme has prioritized efforts to integrate the AIDS response across the broader global health and development agenda. Through normative guidance and technical support, the Joint Programme has aided countries in aligning AIDS planning with other planning processes and in linking HIV services with other service systems.

58. Among countries undertaking midterm reviews, 82 per cent reported addressing integration in their national AIDS strategies, with nearly half (48 per cent) aligning HIV planning with other health-planning processes. More than half (53 per cent) of countries have strengthened HIV/tuberculosis integration; 70 per cent have integrated HIV testing, counselling and services in antenatal care; two thirds have integrated HIV with sexual and reproductive health-care services; 55 per cent have integrated HIV services in general primary care; and a growing number of countries are integrating HIV with services for non-communicable diseases.

59. Growing evidence regarding the effectiveness of cash transfer schemes in preventing new HIV infections underscores the importance of integrating AIDS and social protection. Including funds leveraged by co-sponsors, the Joint Programme

allocated $197 million for activities relating to social protection in the period 2014-2015. In July 2014, the UNAIDS Programme Coordinating Board devoted one day of its 34th meeting to a thematic discussion on strategies to address social and economic drivers of HIV through social protection. In response, the Programme Coordinating Board encouraged the Joint Programme to facilitate country-level dialogues on the linked goals of ending the AIDS epidemic, extreme poverty and inequality and to conduct HIV and social protection assessments to inform national investment approaches.

IV. AIDS post-2015: Ending the AIDS epidemic as a public health threat by 2030

60. At its 35th meeting, the UNAIDS Programme Coordinating Board reaffirmed its commitment to ending AIDS as a public health threat by 2030 and called upon Member States to advocate for the inclusion of this goal in the post-2015 sustainable development goals. The updated and extended UNAIDS strategy for 2016-2021, with the accompanying Unified Budget, Results and Accountability Framework, will be designed to maximize the Joint Programme's contribution towards ending the epidemic.

61. The future of the AIDS response is unfolding in a rapidly changing world. The response is confronted with myriad competing priorities and an evolving funding situation, as well as age-old challenges such as limited human resources, inadequate physical and technical infrastructure in resource-limited settings, and the effects of stigma, discrimination and gender inequalities. Newer, more effective antiretroviral medicines are also more expensive than older drugs, especially the second- and third-line regimens that will be increasingly needed by people living with HIV in future years.

62. Ending the epidemic demands a response that is optimally strategic and sustainable. New partners and champions are needed, and decision-makers need to be persuaded to transcend short-term political priorities and put in place the policies and programmes that will generate long-term health, development and economic returns. The AIDS epidemic cannot be ended unless the needs of those currently left behind are effectively met, underscoring the vital importance of grounding the response in human rights and gender equality.

63. As ample experience has demonstrated, AIDS is much more than a health issue. This highlights the urgent importance of promoting HIV-sensitive approaches and linkages with the AIDS response across the post-2015 development agenda. The Joint Programme has been working to ensure that AIDS is adequately reflected in the post-2015 agenda, advocating for HIV-sensitive indicators in such diverse areas as gender equality, education and partnership to ensure policy coherence and synergistic action to address the social, political and economic determinants of HIV, poor health, poverty and inequality. For example, the Joint Programme has worked to ensure that HIV is a robust component of the post-2015 decent work agenda of the ILO International Labour Council.

64. To end the epidemic, the response will need to effectively reach those currently being left behind. Groups whose needs are not being effectively met by the response include adolescent girls and young women, prisoners, migrants, people

who inject drugs, sex workers, men who have sex with men, transgender people, children living with HIV, displaced persons, people with disabilities and people aged 50 years and older. Overcoming the factors that have prevented greater progress for these groups demands a response that recognizes such populations as natural partners in the quest to end the epidemic by 2030, underscoring the critical need for people-centred approaches that galvanize the participation and leadership of affected communities.

A. Fast track by 2020

65. Modelling led by the Joint Programme identifies the next five years as a narrow window in which to accelerate action and front-load investments to lay the foundation to end the AIDS epidemic. Accordingly, the Joint Programme has embarked on a fast-track strategy to rapidly expedite gains in national responses in the next five years. Implementing the fast-track strategy at the country level requires the establishment of ambitious targets, increased national investments in scaling up priority prevention and treatment interventions, reaching those left behind and removing social, legal and other impediments to scale-up. A more strategic, granular approach that focuses finite resources on high-impact interventions in the geographic areas and populations where the need is greatest is required. In assisting national partners in translating ambitious global targets for 2020 into national targets, the Joint Programme is focusing intensive efforts on the 28 low- and middle-income countries that account for nearly 90 per cent of all new HIV infections.

66. Ambitious targets drive progress, enhance accountability and unite stakeholders. In addition to the 90-90-90 treatment target, the Joint Programme is working on the development of complementary targets for HIV prevention and non-discrimination. The Joint Programme-led modelling indicates that reaching the 90-90-90 target and provisional prevention and non-discrimination targets by 2020 will effectively end the AIDS epidemic as a public health threat by 2030, reducing the number of new HIV infections by 89 per cent and the number of AIDS-related deaths by 81 per cent compared with 2010.

67. Key actors have readily embraced the fast-track agenda. At a 2014 World AIDS Day event, mayors from around the world signed a declaration pledging to end the epidemic in their cities through a fast-track approach. This is a critical commitment to the success of the approach given that a majority of people living with HIV already live in cities, which are expected to account for more than 60 per cent of the world's population by 2050.

B. Delivering the post-2015 AIDS response: shared responsibility and global solidarity

68. To lay the foundation to end the epidemic, low-income countries will require $9.7 billion in 2020, while lower-middle-income countries will need $8.7 billion. Upper-middle-income countries will require $17.2 billion in AIDS funding in 2020; their funding needs will decline to $14.2 billion in 2030.

69. Mobilizing the resources that will be needed to end the AIDS epidemic will require both global resources and increased domestic support for the response. In 2014, UNAIDS outlined a strategy to mobilize essential financing to end the epidemic, based on the principles of shared responsibility and global solidarity.

70. All low- and middle-income countries need to bring domestic AIDS funding into line with their national wealth and HIV burden, which in most countries will require an increase in domestic financing for the response and further increases as national economies grow. Low-income countries will continue to require substantial international support to implement fast-track targets. Lower-middle-income countries should assume a greater share of financial responsibility for their national responses, although those with a heavy HIV burden will continue to need considerable external assistance. Upper-middle-income countries should take immediate steps to transition to self-financing of the response, although special arrangements may be needed where the drawdown of donor funding might result in de-funding of essential programmes for key populations.

71. Countries need to explore innovative financing mechanisms to generate sustainable, renewable funding sources for HIV, such as special tax levies, national lotteries and dedication of unclaimed assets to the AIDS response. In addition to mobilizing new resources, stakeholders need to redouble efforts to ensure that all AIDS funding is used to maximum effect.

72. All providers of financial support for the response, but especially low- and middle-income countries, should consider AIDS funding as an excellent investment that will generate substantial health and economic returns. In 2014, UNAIDS-commissioned modelling found that investments towards ending the AIDS epidemic as a public health threat by 2030 would yield economic returns of $15 per dollar spent.

C. Linking AIDS with broader global health and development

73. In resolution 2013/11, the Economic and Social Council recognized the value of the lessons learned from the global HIV and AIDS response for the post-2015 development agenda, including lessons learned from the unique approach of the Joint Programme. It also recognized that UNAIDS offers the United Nations a useful example, to be considered as a way for the Organization to enhance strategic coherence, coordination, results-based focus and country-level impact in the post-2015 period. These sentiments were also recognized and reaffirmed by the Programme Coordinating Board at its 34th and 35th meetings. The Joint Programme provides inspiration and lessons for broader development efforts through its evidence- and rights-based approaches, underpinned by the values of human rights, equality and sustainability, with inclusive governance and mutual accountability at the core.

74. The outbreak of the Ebola virus disease in West Africa underscores how the AIDS response can support and be linked with broader health issues. The Joint Programme brings experience in a multisectoral, multi-stakeholder response, focused on the poorest and most marginalized, where stigma and discrimination are critical obstacles and where community action and mobilization and human-rights-based approaches are essential. The Joint Programme responded quickly, coordinating efforts with the United Nations Mission for Ebola Emergency Response (UNMEER).

Joint Programme staff members in the region have actively supported UNMEER, and other UNAIDS staff have been voluntarily redeployed to the region. The UNAIDS Executive Director and Deputy Executive Director undertook missions to the region, supporting the Ebola response. In its multifaceted activities, the Joint Programme is working to support essential HIV services in the context of the outbreak of the Ebola virus disease and to support the key UNMEER pillars of the Ebola response. It has also helped to prepare for Ebola vaccine clinical trials.

75. The AIDS response catalyses broader global health and development progress in other ways. In Rwanda, for example, stronger health-care systems as a result of investments in early scale-up of HIV treatment have allowed the country to provide a growing array of health-care services; childhood vaccination rates in Rwanda have reached 97 per cent, and 69 per cent of births are now attended by clinicians in health-care facilities. Similar benefits to the broader health-care system from AIDS funding have been documented in Kenya and other settings.

76. The AIDS response also benefits from integration with broader global health and development efforts. The integration of HIV into other health and social service systems accelerates service scale-up and improves outcomes. The AIDS response also relies on robust non-health sectors. For example, it will be impossible to address human rights violations or reach those currently left behind without the effective involvement of law enforcement and other judicial officers. Nor will it be possible to optimally minimize the risk and vulnerability of adolescent girls and young women without strong collaboration with social protection agencies and national ministries focused on women and families.

V. Recommendations towards ending the AIDS epidemic as a public health threat by 2030

77. **The Economic and Social Council may wish to consider the following actions:**

(a) **Commend the continued support provided by UNAIDS to drive progress on the implementation of the 2011 Political Declaration on HIV and AIDS towards achieving the global vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths, including the assistance provided to countries to ensure timely reporting on progress and to address documented gaps in the response;**

(b) **Acknowledge the historic opportunity to end the AIDS epidemic as a public health threat by 2030, while emphasizing that the epidemic is not over and that the next five years offer a fragile window of opportunity to accelerate the response and lay the foundation to end the epidemic by 2030. In order to ensure that no one is left behind, responses and resources need to be focused on locations and populations where they will have the greatest impact, in line with epidemiological patterns; to be grounded in human rights and gender equality; and to fully engage young people and the most affected populations;**

(c) **Call upon Member States and the Joint Programme to pursue, in line with the common vision of the three zeros, a clear commitment in the post-2015 development agenda to ending the AIDS epidemic as a public health threat and an obstacle for overall sustainable development by 2030, through evidence-**

based interventions to include universal access to HIV prevention, treatment, care, and support, so that AIDS no longer represents a major threat to any population or country;

(d) Reaffirm Council resolution 2013/11, in particular the value of the lessons learned from the global AIDS response for the post-2015 development agenda, including those learned from the unique approach of the Joint Programme; also reaffirm that the Joint Programme offers the United Nations system a useful example, for the post-2015 period, of enhanced strategic coherence, coordination, results-based focus, inclusive governance and country-level impact, based on national contexts and priorities;

(e) Look forward to the high-level meeting on AIDS to be convened by the General Assembly in 2016 and underline the important opportunity provided by this event to further advance the ambitious commitment to end the AIDS epidemic by 2030;

(f) Note the ongoing need to close the AIDS resource gap, in line with the principles of shared responsibility and global solidarity; encourage countries to scale up their domestic funding for the response; and call upon existing and new international donors to reaffirm their commitment and solidarity in the response. At the same time, emphasize that comparable action is needed to ensure value for money in the response, by improving service efficiency and effectiveness and removing obstacles to service delivery, aligning national responses with documented epidemiological patterns and implementing sound investments.